## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 08/06/2013 FORM APPROVED OMB NO. 0938-0391

l i		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151529	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 07/26/2013			
NAME OF PROVIDER OR SUPPLIER  SCHNECK MEDICAL CENTER HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 411 W TIPTON ST PO BOX 2349 SEYMOUR, IN 47274					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION DATE	
L000000			L00	0000				
	This was a hosp & state relicens	pice federal recertification sure survey.						
	Survey Dates:	7/24-26/2013						
	Facility #: 0079	970						
	Medicaid Vend	lor #: 200131630A						
	Team Leader	vn Snider, RN, PHNS						
	RN	y: Joyce Elder, MSN, BSN, ly 30, 2013						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

007970

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00			COMPLETED		
151529		B. WIN	G		07/26/	2013	
NAME OF PROVIDER OR SUPPLIER SCHNECK MEDICAL CENTER HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 411 W TIPTON ST PO BOX 2349 SEYMOUR, IN 47274				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	re l	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	_	DATE
L000537	OF SERVICES The hospice musinterdisciplinary gin paragraph (a) consultation with physician, must paragraph pati	roup or groups as specified of this section which, in the patient's attending repare a written plan of ent.	LOC	00537	L 537The hospice agency will ensure the written plan of care was developed with full		08/23/2013
	review, and inter to ensure the wri developed with f interdisciplinary records (1 - 5, 7 reviewed with th the hospice patie	l record review, policy view, the hospice failed tten plan of care was full participation of the group for 11 of 13 7 - 10, and 14 - 15) e potential to affect all of ents.			participation of the Interdisciplinary Team (IDT) as evidenced by handwritten signature and date on every P of Care.A process change will implemented. All Hospice Plan Care documents will be manua signed and dated by the IDT members during the weekly meeting signifying their participation in the patients pla	lan be n of ally	
	2/25/13, included benefit periods of 5/26/13 - 8/23/13 signature and dar Registered Nurse 2. Clinical recoincluded a plan of periods of 11/29/5/27/13, and 5/23 to evidence all the	d #1, start of care (SOC) d a plan of care for the f 2/25/13 - 5/25/13 and 8 that failed to evidence a te to identify the e (RN) had participated.  rd #3, SOC 11/29/12, of care for the benefit /12 - 2/26/13, 2/27/13 - 8/13 - 7/26/13 that failed the members of the Group (IDG) had			of care.Plans of Care for curre patients will be audited and appropriate staff will sign and date (per agency policy) signifit their participation in the patient plans of care. this retrospective review will be overseen by the administrator. Systematic audit will be performed weekly by the nurse manager for all admission and recertifications to ensure compliance. An inservice was provided to the IDT on August 2013 to discuss the new proceand implement changes. The II will review and update the two policies titled, "Documentation Provision of Care" and "Hospic in a Facility-Plan of Care" to	nt ying tts' e s e ons 5, oss DT	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING  00		(X3) DATE SURVEY COMPLETED		
		151529	B. WING			07/26/	2013
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 411 W TIPTON ST PO BOX 2349 SEYMOUR, IN 47274				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΙΤΕ	(X5) COMPLETION DATE
	A. The plan periods of 11/29 - 5/27/13 failed and date to ident participated.  B. The period of 5/28/11 evidence a signathe RN had participated aplan of periods of 4/9/13 that failed and date to ident participated.  4. Clinical reconsinct aperiods of 1/23/17/21/13 that failed and date to ident participated.  5. Clinical reconsinct aperiod of 7/9/13 evidence a signathe RN had participated.	as of care for the benefit /12 - 2/26/13 and 2/27/13 to evidence a signature cify the RN had  lan of care for the benefit 3 - 7/26/13 failed to ture and date to identify cipated.  at #5, SOC 4/9/13, of care for the benefit 3 - 7/7/13 and 7/7/13 - ed to evidence a signature cify the RN had  at #7, SOC 1/23/13, of care for the benefit 13 - 4/22/13 and 4/23/13 - ed to evidence a signature cify the RN had  at #9, SOC 7/9/13, of care for the benefit 13 - 4/26/13 that failed to cuture and date to identify			include the new process demonstrating alignment with regulation. A 10% random san of Plan of Care documents wi audited monthly for hand writ signatures and dates for all ID members in the plan of Care 100% compliance is achieved. This plan of correction will be completed by August 23, 2013. The Hospice Administra will be responsible for ensurin this deficiency is corrected an will not recur.	nple II be ten T until tor	
	included a plan of care for the benefit						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00			COMPLETED	
151529		B. WIN	G		07/26/2013	
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE	
					FIPTON ST PO BOX 2349	
SCHNEC	SCHNECK MEDICAL CENTER HOSPICE			SEYMO	DUR, IN 47274	
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION SHOULD BE		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	period of 5/13/13 - 8/10/13 that failed to					
	_	ture and date to identify				
	the RN had parti	cipated.				
		rd #15, SOC 7/9/13,				
		of care for the benefit				
		- 10/6/13 that failed to				
	_	ture and date to identify				
	the RN had parti	cipated.				
	8. On 7/26/13 at 3:15 PM, Employee J, the clinical manager, and Employee K, administrator, indicated all members of					
	the IDG had not	signed the plans of care.				
	9. Clinical record	d #2, start of care (SOC),				
	12/13/12, includ	ed plans of care for the				
	benefit periods 1	2/31/12 to 3/30/13,				
	3/31/13 to 6/28/1	13, and 6/29/13 to				
	8/27/13 that faile	ed to evidence all				
	members of the	IDG had participated.				
	A. The plan of	of care for the benefit				
	_	12 to 3/30/13 failed to				
	evidence a signa	ture and date to identify				
	the RN and the c	haplain had participated.				
	B. The plan o	of care for the benefit				
	_	3 to 6/28/13 failed to				
	-	ture and date to identify				
	the RN had participated.					
		1				
	C. The plan of	f care for the benefit				
	_	3 to 8/27/13 failed to				

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	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 411 W TIPTON ST PO BOX 2349 SEYMOUR, IN 47274					
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	1	ture and date to identify ervices, and chaplain had						
	included a plan of period of 7/5/13	ord #4, SOC 7/5/13, of care for the benefit to 10/2/13 that failed to atture and date to identify acipated.						
	11. Clinical record # 8, SOC 5/23/13, included a plan of care for the benefit period of 5/23/13 to 8/20/13 that failed to evidence a signature and date to identify the RN had participated.							
	included a plan of period of 7/8/13	ord #10, SOC 7/8/13, of care for the benefit to 10/5/13 that failed to ture and date to identify cipated.						
	included a plan of period of 7/13/1	ord # 14, SOC 7/13/13, of care for the benefit 3 to 10/10/13 that failed gnature and date to had participated.						
	10/10 titled "DC PROVISION OI Signatures (first	with a current review date occumentation of F CARE" states, "3. initial and entire last num)/and/or electronic ermitted for all						

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SF CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	documentation 5. Entries should be made in ink/or by electronic signatures with full dates, signatures and titles.				
	15. The policy with a current review date 6/11 titled "HOSPICE IN A FACILITY-COORDINATED PLAN OF CARE" states, "8 Signatures will be required to document this coordinated and accepted plan of care."				

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